MEDVET
Leading Specialty Healthcare for Pets

Outpatient Ultrasound Referral Form

Date: _____

Referral Partner Information

Referring Veterinarian: _____ **Clinic/Practice Name:** _____

Phone: (_____) _____ **Fax:** (_____) _____ **Email:** _____

Patient Information

Client Name: _____ **Phone:** (_____) _____

Patient Name: _____ ☐ **Canine** ☐ **Feline** ☐ **Other:** _____

Breed: _____ **Sex:** ☐ M ☐ MN ☐ F ☐ FS **Age:** _____

Radiographs Submitted: ☐ Yes ☐ No Digital: ☐ Sent to DICOM Server ☐ CD Analog: ☐ Mailed in ☐ Sent with Owner

Referral Practice

☐ MedVet Chicago
☐ MedVet Cincinnati
☐ MedVet Columbus
☐ MedVet Dayton
☐ MedVet Indianapolis
☐ MedVet Mandeville
☐ MedVet New Orleans
☐ MedVet Toledo

Study Information

☐ Abdomen
☐ Thorax
☐ Neck
☐ Other: _____

Reason for Referral/Primary Complaint:

Clinical Exam/Pertinent Labwork Findings/Working Diagnosis:

Specific Questions to be Addressed:

The radiologist will contact the referral partner following the ultrasound exam to review the results. If there are any questions prior to the appointment date, please contact the radiology department.

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Our Locations:

MedVet Chicago
3305 N. California Ave.
Chicago, IL 60618
Main: 773.281.7110
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Fax: 513.561.5688
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